

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ Gender: [] M [] F Married: [] Y [] N
Work Phone _____ Wireless Phone _____
Email _____
Preferred contact method [] HmPhone [] WkPhone [] WirelessPh [] Email
Preferred contact method for confirmations [] HmPhone [] WkPhone [] WirelessPh [] Email
Preferred contact method for recall [] HmPhone [] WkPhone [] WirelessPh [] Email
Student status if dependent over 19 (for ins) [] Nonstudent [] Fulltime [] Parttime
How did you hear about us?

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____
Check box if same for entire family []

INSURANCE POLICY 1

Your relationship to subscriber: [] Self [] Spouse [] Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [] Self [] Spouse [] Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

Comments:



Patient Name: _____

DENTAL HISTORY

Date of:

Last cleaning _____/_____/_____
 Last oral cancer screening _____/_____/_____
 Last complete X-rays _____/_____/_____

Name of previous Dentist: _____
 City/State: _____

	Y	N
Interested in whiter teeth:	<input type="checkbox"/>	<input type="checkbox"/>
Interested in replacing metal fillings:	<input type="checkbox"/>	<input type="checkbox"/>
Interested in Braces/Orthodontics:	<input type="checkbox"/>	<input type="checkbox"/>
Interested in replacing missing teeth:	<input type="checkbox"/>	<input type="checkbox"/>

	Y	N
Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
Jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Grinding/clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>
Loose/shifting teeth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/swollen/painful gums	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had:

Denture	<input type="checkbox"/>	<input type="checkbox"/>
Partial denture	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal therapy/deep cleaning	<input type="checkbox"/>	<input type="checkbox"/>
Braces	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

	Y	N
Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis (heart infection)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Heart Stent	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
**What Joint _____ Year _____		

	Y	N
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
HPV	<input type="checkbox"/>	<input type="checkbox"/>
STDs	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>

*Other Conditions _____

ALLERGIES

	Y	N
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (NSAIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Morphine	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Valium	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

MEDICATIONS (Please list all medications you are currently taking)

Have you ever taken any medication for Osteopenia/Osteoporosis or Bone Disease, including any of the following medications? (please circle)

Actonel, Aredia, Boniva, Fosamax, Reclast, Zometa, other _____

Current Primary Care Physician: _____

Phone Number: _____

CONSENT: The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental/health needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetics embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

 Patient Signature

 Date



FINANCIAL AGREEMENT

- * For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- * I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- * If sent to collections, I agree to pay all related fees and court costs.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * I agree to inform the office with a 24 hour notice if I am unable to keep my appointment.
- * Treatment plans may change, and I will be responsible for the work actually done.

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

APPOINTMENT POLICY

- Our goal is to provide quality dental care to all of our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our provider, but our other patients as well.
- * If you need to cancel your appointment, please call us as soon as possible. If you cannot reach a scheduling coordinator, please leave a detailed message.
 - * We will reach out to you two weeks prior to your appointment as a reminder call.
 - * We will call two days before your appointment to confirm, if we do not receive a confirmation call within 24 hours, we reserve the right to cancel your appointment.
 - * After three (3) failed appointments, we will be unable to schedule you for future appointments and you will be added to a Same Day List.

I have read and understand all of the above information regarding Franklin Dental's financial agreement, privacy policies, and appointment policy.

Signature _____ Date _____



Franklin Dental

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- Sensitive Protected Health Information (HIV- related information)
- You may disclose information to my family members and/or non-family members

Please list the name, phone number and relationship

<u>NAME</u>	<u>PHONE NUMBER</u>	<u>RELATIONSHIP</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number _____
- You may email me (unencrypted) for dental appointments:
Email Address: _____

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

(Patient's Signature (or Guardian, if minor))

Date: _____